

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$7,346.13 for date of service 02/08/01.
- b. The request was received on 02/07/02.

II. EXHIBITS

1. Requestor:
 - a. Initial Submission of TWCC-60
 1. UB-92
 2. EOB(s)
 3. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC-60 Response to a Request for Dispute Resolution dated 06/24/02
 - b. UB-92
 - c. EOB(s)
 - d. Reimbursement data
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. There is not a carrier sign sheet submitted with the dispute packet. The carrier did submit three responses to the dispute dated 02/11/02, 04/30/02, and 06/24/02. Furthermore, the Commission notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/10/02. There is no 14 day additional information from the provider in the case file. The carrier's 06/24/02 response is considered timely. All information in the file will be reviewed.
4. The TWCC request for additional 14 day information sent to the provider dated 06/10/02 is reflected as Exhibit #III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: No Response
2. Respondent: letter dated 06/24/02;
“Provider billed Carrier \$10,615.13.... Carrier reduced the bill to a fair and reasonable amount using denial code ‘M’ and reimbursed Provider \$1,716.00...” The carrier’s methodology includes a schedule using reference points set in the Commission’s per diem rates in the TWCC Acute Care Inpatient Hospital Fee Guideline, the Medicare payment rates for ambulatory surgical procedures, the payments rates established by the workers’ compensation authorities in Nevada, Massachusetts, Pennsylvania, and Mississippi, and the recent decisions of the State Office of Administrative Hearings.

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only date of service eligible for review is 02/08/01.
2. Per the TWCC 60, the provider billed a total of \$8,815.13 on the date of service in dispute.
3. Per the TWCC, the carrier did not reimburse the provider any monies on the billed services. The denial code is “M – Reduced to Fair and Reasonable.”
4. The amount in dispute per the TWCC-60 is \$7,346.13.
5. In the dispute packet, both the provider and the carrier submitted EOB(s) indicating that provider billed the carrier a total of \$10,615.13 for the date of service and that the carrier reimbursed the provider \$1,716.00. Therefore, the accurate amount in dispute is \$8,899.13.

V. RATIONALE

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401(a)(4) states ASCs, “shall be reimbursed at a fair and reasonable rate...”

Section 413.011(b) of the Texas Labor Code states, “Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.”

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. Regardless of the carrier's methodology or lack thereof, or a timely or untimely response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. Based on the evidence available for review, the provider did not meet the criteria of Rule 413.011 (b) or 133.307 (g) (3) (D) and did not prove that the carrier's reimbursement is not fair and reasonable. Therefore, the provider is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 13th day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

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